Cary Scott Counseling
A NEW DAY, A NEW EXPERIENCE, A NEW BEGINNING

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# AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION*

CHILD'S NAME:_______________________________________ BIRTH DATE:_______________

I, ___________________________________________________________________, residing at

_____________________________________________________, hereby give my consent to

Cary Scott to release and receive personal health information contained in my child's Clinical Record regarding:

mental health: _____ other: _____________________________________

medical history: _____ _____________________________________

family history: _____

**to/from:**

Pediatrician: ________________________________________________________________

Phone: _______________________________ Fax: ______________________________

Address: _____________________________________________________________________

Evaluator/Psychologist: __________________________________________________________

Phone: _______________________________ Fax: ______________________________

Address: _____________________________________________________________________

Psychiatrist: _________________________________________________________________

Phone: _______________________________ Fax: ______________________________

Address: _____________________________________________________________________

Other: _______________________________________________________________________

Relationship to Patient: __________________________________________________________

Phone: _______________________________ Fax: ______________________________

Address: _____________________________________________________________________

for the purpose of ("continuity of care" if left blank):

_____________________________________________________________________________ .

I understand that this is valid until (indefinite if left blank) _____________, that I may withdraw my consent at any time, and that I have a right to receive a copy of this authorization form. I also understand that the information being disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by this privacy rule.

________________________________________ _____________

Signature of Parent/Guardian, relationship Date

________________________________________ _____________

Signature of Parent/Guardian, relationship Date

* Compliant with the *Health Insurance Portability and Accountability Act* (HIPAA).